

The Role of Education in Safe and Effective Pain Management

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“Multiple opportunities for training do not necessarily lead to quality instruction – When something has a bunch of different homes, in fact, it sometimes has no home.”

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Thomson, P. *Lessons of Pain: A Symptom Stretched Across All Specialties*. The New Physician Vol. 55:8, 2006

The Landscape

- **Healthcare Providers**
 - Experts
 - Non-experts
- **Where are the pain patients presenting?**
- **Who's doing the prescribing?**
 - The majority of opioids are prescribed by Primary Care Clinicians¹
 - **Family Practitioners (28.8%)**
 - **Internists (14.6%)**
 - **Dentists (8%)** – *Largest group of prescribers age 10-19*
 - Most prescriptions were for hydrocodone- and oxycodone-containing products (84.9%, 67.5 million) and issued for short treatment courses (19.1% for 2 weeks, 65.4% for 2-3 weeks)

Perspective on Education

- **Where *is* the education?**
 - Many feel it is not there at all, and the **educational deficits are substantial**
 - Pain education was identified in 1988 as an important remedy for the under-treatment of pain¹
 - Progress toward effective programs that educate future clinicians has been slow²
 - Lack of pain education in medical schools and non-specialty training programs²
 - *"Pain education for North American medical students is limited, variable, and often fragmentary"*
 - Although a majority of medical schools are teaching one or more core topics in pain, a large number of U.S. medical schools are not reporting any teaching of pain and an equally large number devote fewer than 5 hours to the topic²
 - *"Even though the importance of integrated pain courses is widely recognized, only 4% of U.S. medical schools currently report having such courses"*

1. Pilowsky I: *An outline curriculum on pain for medical schools*. Pain 33:1-2, 1988

2. Mezei et al. *Pain Education in North American Medical Schools*. The Journal of Pain, 12:12 (December), 2011: 1199-1208

Perspective on Education

- In one study¹, 59 % of respondents rated their medical school education on pain management as “fair” or “poor”
 - 36 % said the same about their residency education
- Lack of confidence in treating chronic noncancer pain described among physicians in practice and individuals in training
 - Reasons include:
 - Lack of preparation
 - Barriers to effective pain management
 - Federal and state regulatory restrictions
 - Competing demands at both the institutional and residency program levels

1. Yanni LM, et al. *Preparation, confidence, and attitudes about chronic noncancer pain in graduate medical education*. J Grad Med Educ 2010 (2):260–268

The Need for Education

- Over 80% of attending physicians rate their medical school education about chronic pain treatment as inadequate¹
- 33% of PCPs screen for substance abuse²
- 16.9% view themselves as “very prepared” to detect aberrant drug-related behavior²
- 30.2% see themselves as “very prepared” to detect prescription drug abuse²

1. Upshur CC, Luckmann RS, Savageau JA. *Primary care provider concerns about management of chronic pain in community clinic populations*. J Gen Intern Med. 2006;21(6):652–655.

2. National Center on Addiction and Substance Abuse at Columbia. *Missed opportunity: national survey of primary care physicians and patients on substance abuse*. Columbia University, Center on Addiction and Substance Abuse 2000. Available at: http://www.casacolumbia.org/templates/Publications_Reports.aspx#r41. Accessed September 21, 2012.

Experts and PCPs

- Aspects in common
 - Have time constraints
 - Have high patient volume
 - Face economic challenges in current atmosphere
- **Experts** have the education and paradigms in place, don't want clinical guidance, and don't want unnecessary referrals and consults
- **PCPs** want guidance and resonating paradigms, and need more time

Progress in Education?

- *“In many ways, America’s approach to addiction treatment today is similar to the state of medicine in the early 1900s”¹*
 - In 1908, the Council on Medical Education of the American Medical Association turned to the Carnegie Foundation for the Advancement of Teaching to conduct a survey of Medical Education in the U.S.
 - That survey, which became known as The Flexner Report, was led by Abraham Flexner who famously observed of the discrepancy among physicians’ qualifications, *“there is probably no other country in the world in which there is so great a distance and so fatal a difference between the best, the average and the worst.”*
 - *“This CASA Columbia report identifies a similar gulf in the knowledge and practice skills of addiction treatment providers today”*

1. National Center on Addiction and Substance Abuse at Columbia. *Accompanying Statement by Drew E. Altman, PhD, Chair, The CASA Columbia National Advisory Commission on Addiction Treatment* Columbia University, Center on Addiction and Substance Abuse 2000. Available at: <http://www.casacolumbia.org/templates/ChairmanStatements.aspx?articleid=681&zoneid=31> . Accessed September 21, 2012

Where Should Education Come From?

- Typically, providers of educational content for non-expert clinicians rely on national experts to develop the curriculum^{1,2}
- However, because pain and addiction specialists may offer differing perspectives (treat all pain patients vs. concern about addiction risks), many PCPs are left to weigh the risks in the absence of critical pain and opioid risk management skills³
- As a precursor to needs assessment, the identification of these skills is an important step in addressing this challenge⁴

1. Alford DP, Bridden C, Jackson AH, et al. *Promoting substance use education among generalist physicians: an evaluation of the Crief Resident Immersion Training (CRIT) program.* J Gen Intern Med. 2008;24(1):40–47.

2. Harris JM Jr., Elliott TE, Davis BE, Chabel C, Fulginiti JV, Fine PG. *Educating generalist physicians about chronic pain: Live experts and online education can provide durable benefits.* Pain Med. 2008;9(5):555– 563.

3. Chou R, Fanciullo GJ, Fine PG, et al. *Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain.* J Pain. 2009;10:113– 130.

4. Chiauzzi, E, Trudeau, KJ, Zacharoff, KL, Bond, K. *Identifying Primary Care Skills and Competencies in Opioid Risk Management.* Journal of Continuing Education in the Health Professions, 2011 31(4):246–255

What *do* People Need to Learn?

Primary Care Physicians	Pain Management Specialists
Managing pain and co-morbid conditions	Managing pain and co-morbid conditions
Understanding aberrant drug-related behavior	Formulating a treatment plan
Formulating a treatment plan	General aspects of pain management
How to monitor patient compliance in clinical practice	Teaching patients about medication safety
Understanding the practical issues of addiction	Understanding aberrant drug-related behavior
How to ensure safe and appropriate prescribing of opioids	Understanding the practical issues of addiction
Teaching patients about medication safety	How to monitor patient compliance in clinical practice
Understanding the importance of having a medical home	How to ensure safe and appropriate prescribing of opioids
General aspects of pain management	Understanding the importance of having a medical home
Understanding the social impact of pain	Understanding the social impact of pain

- 1. Chiauuzi, E, Trudeau, KJ, Zacharoff, KL, Bond, K. *Identifying Primary Care Skills and Competencies in Opioid Risk Management*. Journal of Continuing Education in the Health Professions, 2011 31(4):246-255

Guidelines and Clinical Practice

- **Guidelines**
 - Don't often change clinical practice¹
 - May or may not resonate with non-expert clinicians
 - Are poorly disseminated to the "masses"
 - Have low evidence basis, creating doubt and lower uptake non-expert audiences

1. Corson et al. *Primary Care Clinician Adherence to Guidelines for the Management of Chronic Musculoskeletal Pain: Results from the Study of the Effectiveness of a Collaborative Approach to Pain*. *Pain Medicine* 2011; 12: 1490–1501

Education Can Make a Change

- For effective education, we need to apply existing and familiar paradigms that resonate with clinicians
 - e.g., Warfarin
- Healthcare providers can in a relatively short period of time can cover all of the aspects of:
 - Assessment
 - Informed decision-making
 - Informed Consent
 - Discussion including monitoring requirements
 - Follow-up

Educational Frameworks

- *Existing frameworks need to be bridges to new ones in order to succeed, instead of trying to replace them*
- Decade of pain control and research vs. over-prescribing of opioids
- Old definition of risk vs. new definition
 - Adverse effects vs. aberrant drug-related behavior
 - Informed consent, monitoring, etc.

The Patient-Centered Home

- *"We should make primary the goal of teaching pain medicine physicians to:*
 - *Know how to manage the challenges of living with a chronic condition*
 - *Learn how to inform and activate patients to take responsibility for self-management using the skills of empathy and motivational interviewing"*

Patient Education

- Tools to educate patients
 - Medication safety
 - Adverse effect recognition
 - Breakthrough pain
- Realistic goal-setting instead of a “silver-bullet” approach
- Shared decision-making
- Identification of responsibility
- Self-management strategies

Conclusions

- *“Educational emphasis in pain management should also focus on medication safety, as evidenced by a recent study on overdose deaths in noncancer pain syndromes treated with opioids”¹*
- Currently, there are no educational mandates
 - Associated with DEA registration
 - Associated with medication scheduling
- Meaningful education could be achieved in a variety of ways including:
 - FDA focus on opioid risk-mitigation strategies
 - Curricula in training programs
 - Start from the beginning
 - Clinically-relevant information for *real people* in practice

1. Yanni LM, et al. *Preparation, confidence, and attitudes about chronic noncancer pain in graduate medical education.* J Grad Med Educ 2010 (2):260–268

When it Comes to
Education, We Need
Coordination *not*
Fragmentation

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